IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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July 14, 2008

Sandra Bruce
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

Provider #130007

Dear Ms. Bruce:

On **June 25, 2008**, a Complaint Survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003415

Allegation #1: The Emergency Department (ED) staff failed to appropriately evaluate and treat patients who presented to the ED with chest pain.

Findings: Surveyors made an unannounced visit to the hospital, arriving on 6/23/08 and exiting on 6/25/08. During the visit, surveyors reviewed nine records, examined ED policies and procedures relating to evaluation and treatment of chest pain, and interviewed administrative and ED staff.

The hospital ED had written protocols relating to chest pain evaluation and treatment. The protocol "Coronary Syndrome, Acute," was utilized for the initial evaluation and treatment of patients with chest pain. The protocol "ST Elevation Myocardial Infarction (STEMI)" was utilized for further evaluation and treatment of patients identified on electrocardiogram (EKG) with an ST elevation.

During an interview on 6/25/08, at approximately 9:00 AM with ED staff, the ED director explained that the chest pain protocols were intended as guidelines for assessment and intervention, subject to individual evaluation of patients' conditions and professional physician and nursing judgment.

The records of nine patients presenting to the ED with chest pain were reviewed and documented that ED staff generally followed established protocols and documented consistent interventions in the initial evaluation and treatment of patients presenting with chest pain.

Minor variances in documentation were noted in the use of oxygen and the ordering of prothrombin time (PT) and partial thromboplastin time (PTT) as part of the initial evaluation. During interview of ED staff on 6/25/07 at approximately 9:00 AM, these variances were explained for each patient based on the individuals' documented conditions and factors such as oxygen saturation levels, patient appearance, respiratory status, history of anticoagulants and/or anticipated use of anticoagulants.

Although the allegation may have occurred, it could not be substantiated during the complaint investigation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The Emergency physician failed to order a CAT scan (computed-assisted tomography) in a patient presenting to the Emergency Department (ED) with chest pain.

Findings: Surveyors made an unannounced visit to the hospital, arriving on 6/23/08 and exiting on 6/25/08. During the visit, surveyors reviewed nine records, examined Emergency Department (ED) policies and procedures relating to evaluation and treatment of chest pain, and interviewed administrative and ED staff.

Review of nine of nine records revealed that ED staff did not order any CAT scans as a part of the initial evaluation for the nine patients presenting with chest pain. This finding was consistent with the ED protocol "Coronary Syndrome, Acute," used by the ED for evaluation of chest pain; the protocol does not call for standardized ordering of CAT scans.

On 6/25/07 at approximately 9:00 AM, an ER Physician reviewed the patient's record. He stated he did not want to second guess his collages decisions but did not see a real indicator as to why his collage should have ordered a CT.

Although the allegation may have occurred, it could not be substantiated during the complaint investigation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

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July 22, 2008

Sandra Bruce
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

Provider #130007

Dear Ms. Bruce:

On **June 25, 2008**, a Complaint Survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003429

Allegation #1: The hospital does not provide appropriate discharge planning for patients.

Findings: The allegation of inadequate discharge planning was investigated during a survey completed 9/10/07. The hospital was found to be out of compliance with the Medicare Condition of Participation on Discharge Planning and subsequently submitted an allegation of compliance that was found to adequately address the problem. A follow up survey found the hospital in compliance with the Condition of Participation of Discharge Planning on 10/19/07.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The hospital does not include family members in the plan of care.

Findings: An unannounced visit was made to the hospital on 6/23/08. Five closed records of patients who had been admitted to the Telemetry Unit with the diagnosis of Atrial Fibrillation were reviewed. Policies were reviewed. The manager of Telemetry was interviewed. A Case Manager was interviewed.

One record indicated a patient had been admitted to the Telemetry Unit from the Emergency Department on 10/30/08. The patient had a history of mitral valve repair with the current diagnosis of Atrial Fibrillation. After a cardiac work-up, she was scheduled for mitral valve replacement. She expired during the surgery on 11/6/08. Documentation showed that the patient had signed her own Consent for Treatment, Surgical Permit, as well as permits for procedures done on 10/31/08 and 11/1/08. There were no designated Power of Attorney documents present in the record. The Case Manager for the patient assessed and spoke with the patient on 10/31/07. The Case Manager was interviewed on 6/24/08 at 2:00 PM. It was her opinion that the patient was cognitive and capable of making decisions about her medical care. The case manager stated that Power of Attorney forms are provided, at the family's request or, if the patient's abilities are in question, the case manager will intercede with the doctor, social worker or family.

The hospital's policy titled "HIPPA - PATIENT INFORMATION INQUIRIES" was a guideline for handling inquiries regarding a patient. It stated, "All in-patients will be assigned a privacy number. The patient may share this number with the persons she/he wishes to receive status or condition reports and have involved in their care".

When interviewed on 6/24/08 at 1:30 PM, the manager of the Telemetry Unit stated the privacy number is given to the patients at the time of admission to the unit. She further stated nursing staff do not give test results to the patient or family members. Rather, nursing staff defers to the physician to discuss test results. She also stated if a family member requests to speak to a doctor, the nursing staff would address the request by paging or calling the doctor. If there is no response, nursing will leave a note on the front of the chart.

Further, the hospital's policy titled "PATIENT RIGHTS AND RESPONSIBILITIES" stated it was the right of each patient "...to receive care that protects your personal privacy and keeps your clinical records confidential including accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)".

According to case manager notes, dated 11/2/08 at 2:20 PM, a conversation occurred, including the patient, family member, case manager and the physician. Power of Attorney forms were given to the family member by the case manager. The family member was included in the patient's care planning after this point. The patient's cardiac care providers were changed.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PATRICIA O'HARA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PO/mlw

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July 14, 2008

Sandra Bruce
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

Provider #130007

Dear Ms. Bruce:

On **June 25, 2008**, a Complaint Survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003545

Allegation: Patient and/or family member requested hospital records from 2002. Complainants reported that they did not receive records as requested.

Findings: Surveyors made an unannounced visit to the hospital, arriving on 6/23/08 through 6/25/08. Surveyors reviewed nineteen medical records. Five of the nineteen records contained "Request for Access to Health Information in a Designated Record Set Held by (Hospital Name)." In addition to reviewing records, surveyors interviewed staff from the Department of Medical Records to become familiar with the process of responding to patient/family requests.

Review of records showed that four out of eight record requests (relating to five records) were fulfilled fully and in a timely manner. Three of the eight requests related to one individual record. Of the three requests, dated 8/18/06, 10/20/06, 11/03/06 and 05/06/08, medical records failed to provide the patient/family with the hospitals "EMTEC" charting notes on the 10/20/06 request. The hospital corrected the omission and on 11/03/06 the hospital provided the "EMTEC" notes to the patient/family.

Substantiated. However, the facility was not cited as they acted appropriately by correcting their error on 11/03/06 and providing all documents as requested by the patient/family on 10/20/06.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw